Policy Shifts and Their Impact on Health Care for Elderly Persons

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Three major shifts in federal policy have been initiated recently that will directly affect the medical care of the elderly: (1) A significant reduction in federal expenditures for domestic social programs; (2) decentralization of program authority and responsibility to states, particularly through block grants; (3) deregulation and greater emphasis on market forces and competition to address the problem of continuing increase in the costs of medical care.

The federal policy shifts come at a time when many state and local governments are experiencing fiscal strain or fiscal crisis due, in part, to the rapid rise in expenditures for medical care for the poor and the imposition of limitations on, and even reductions in, tax revenues.

In the short term, changes at the state level, particularly limitations on Medicaid expenditures, are likely to have the most profound effect on medical care for the elderly. These changes will most likely include reductions in Medicaid eligibility and in scope of benefits as well as tight controls on hospital, nursing home and physician reimbursement.

NOT SINCE the debate on Medicare has federal policy affecting the elderly attracted so much attention. The changes in federal domestic social policy have been described as "massive," "revolutionary" and "drastic." Although the changes may seem to be dramatic and of very recent origin, they are, in fact, rooted in changes in the economy and public policy that began more than a decade ago.[1] In examining the potential effects of changes in the economy on physicians, on medical care, and on research and teaching, Fuchs observed that the likely impact of current trends will be a reduced flow of funds for patient care, research and training in the 1980's.[2] Blendon and coworkers stated that the decreased rate of economic growth in the 1980's will have a disproportionate impact on public expenditures, including those for health care, and they predicted an era "of challenge and stress for America's health institutions."[3] Geiger, who observed that conditions for the elderly have grown worse since the mid-1970's, noted that "social policy currently portends a decade of disaster for the health of older Americans, regardless of our ultimate actions in the area of medical care."[4]

The impact of changes in the economy and changes in federal policies that are attracting so

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ABBREVIATIONS USED IN TEXT

AFDC = Aid to Families With Dependent Children (program)
FY = fiscal year
GNP = gross national product
HMO's = health maintenance organizations
SSI = Supplemental Security Income (program)

much attention can be viewed from the standpoint of individual persons or groups of persons who are affected, programs and institutions, local and state governments, or areas of the country (for example, the Northeast may be more severely affected than the Southwest).

Although many policymakers, policy analysts and health professionals view the shifts—particularly the budget cuts in domestic social programs—as essential to combat inflation, they seem less certain about the impact of these shifts on services for those who are largely dependent on public programs and institutions that provide those services. This uncertainty exists because there have not been detailed analyses of the federal policy shifts in relation to the growing fiscal problems in many state and local jurisdictions.

Our own studies in health and aging policies during the past decade have convinced us that the next few years will be difficult, challenging and troubled times for the elderly and for those who provide medical care for this population. The problems arise mainly because of the continued rapid increase in the cost of medical care, particularly hospital care, and the fiscal crisis that is affecting local, state and, now, the federal government.

In this paper we will discuss three major federal policy shifts that will affect medical services, including long-term care for the elderly. We will examine these policy shifts in relation to the concepts of fiscal crisis and decentralization. Not only will access of older persons to medical care be affected by the changing policies, but physician-patient relationships and the capacity of the independent sector (nonprofit), public and profit-making institutions to provide necessary services may be vitally affected as well.

The three major shifts in federal policy that will directly affect the medical care of the elderly are (1) a significant reduction in federal expenditures for domestic social programs; (2) decentralization of program authority and responsibility to the states, particularly through block grants; and (3) deregulation and greater emphasis on market forces and competition to address the problem of the continuing increase in the cost of medical care.

A fourth policy development of major importance, the Economic Recovery Tax Act, may have many indirect effects on health care for the elderly, but these will be mediated largely through philanthropic contributions to independent (nonprofit) sector institutions. These are difficult to gauge at present. Two of the policy initiatives have already been adopted by congress in the Omnibus Budget Reconciliation Act of 1981 and signed into law by the President. The cuts in federal spending and the decentralization of program authority to the states spelled out in the act respond to problems (for example, fiscal crisis) and build on policies (such as new federalism) that began to emerge in the early 1970's. We believe that the fiscal constraints at the state and local levels will have a more dramatic effect on medical care for elderly people who are poor than will the federal policy shifts.

The Concept of Fiscal Crisis and Reduced Federal Expenditures

Fiscal crisis is a concept that has had a major impact on the policies of local and state governments. In the past the term fiscal crisis had been used to describe the problems of a local government that could not service its debts (for example, New York City and Cleveland) or of a state whose expenditures exceeded its revenues. The term fiscal crisis is now being applied to federal expenditures for social programs.

Since 1975 there has been a decline in federal, state and local expenditures as a percent of the gross national product (GNP) and a decline in per capita expenditures in constant dollars.[5(p4)] After intergovernmental transfers (such as federal and state to local, or federal to local), the most significant declines are at the local level.[5(p6)] Since 1975 state and local expenditures have declined from 15.1 percent to 13.5 percent of the GNP, while federal expenditures have decreased from 12.3 percent to 11.9 percent of the GNP.

The fiscal problems are further compounded by the fact that there are five different classes of local governments competing for increasingly limited funds: counties, municipalities, townships, school districts and special districts. In most states, the counties and municipalities are primarily responsible for health and hospital services, but in

some states, special hospital districts also play an important role. Competing for these limited funds are education, public welfare, highways, police, fire, corrections, sewage and other sanitation services, housing and urban renewal, parks and recreation, government administration and, increasingly important, interest on government borrowing.

Fiscal crisis at the local level will be exacerbated because of the severe cutbacks in direct local federal aid. The community development block grants and the comprehensive employment and training block grants have been eliminated, and others have been significantly reduced.[6]

Two issues link fiscal crisis and health care for the aged: (1) the escalation in expenditures for medical services for the elderly, partly due to increased access and increased numbers of older people, but primarily due to the rising cost of medical services, and (2) the imposition of limitations on, and even reductions in, revenues for such services at the state and local levels.[7,8] While costs are escalating there are definite limits on funding for health and social services.

From above there are (1) federal limits on Medicaid expenditures and (2) major block grant initiatives with a 25 percent reduction in the funding level of the prior categorical programs that the block grants replace. Both of these conditions are shifting medical care costs to the states, to local governments and to the elderly themselves.

From below there are fiscal crises and tax revolts at the state and local levels. Caught in the squeeze, health and social services are involved in a "fiscal crisis" of their own. During the 1980's all levels of government will seek to cut costs and shift expenditures to other jurisdictions. For example, at least half of the states were planning Medicaid cuts before the enactment of the Omnibus Budget Reconciliation Act of 1981. Many more will follow suit as a result of the limits that the act placed on the federal share of Medicaid costs.

These fiscal pressures at multiple government levels pose a particular problem for Medicaid-funded services because of the magnitude and rapid increases in these expenditures, now outrunning the capacity of states to raise the necessary revenue.[9] In view of the Medicaid expenditure escalation (Medicaid costs have risen more than 500 percent between 1968 and 1978, from $3.5 billion to $18 billion), and the fact that 20 percent of the elderly receive Medicaid and 39 percent of Medicaid expenditures are for the elderly, the cost-containing policy changes at the state level are likely to affect the elderly directly. The federal Medicaid expenditure limitation* and the difficulty that many states face in funding Medicaid will require (1) a major effort by the states to contain costs in the Medicaid program itself and (2) policy modifications in other state benefits that could directly and adversely affect health care for the elderly.

Long-term care services for the elderly will be affected in several ways: reductions in supplementary income support—such as reductions or elimination of state supplementation or cost of living increases in Supplemental Security Income (SSI) benefits for the poor elderly; and reductions in such social services as state supplementation of vitally needed homemaker, home health and adult day health services under Title XX of the Social Security Act (this has been cut 25 percent, from $2.9 billion to $2.4 billion, under the Social Services block grant).

The Omnibus Budget Reconciliation Act includes a number of provisions related to Medicare and Medicaid that are expected to reduce federal expenditures for these programs in fiscal year (FY) 1982 by $2.5 billion. The 3 percent reduction in the federal share of Medicaid expenses is only one of these policy changes. Among the more important Medicaid policy changes are (1) states are given greater flexibility with respect to coverage of and services for the medically needy, (2) states no longer need to reimburse hospitals at the Medicare rate, (3) the freedom of choice provision of the state Medicaid plan can be waived by the Secretary of Health and Human Services and (4) participation in health maintenance organizations (HMO's) is encouraged.

The Medicare policy changes in the Omnibus Budget Reconciliation Act of 1981 increase significantly the copayments and deductibles paid by older persons. The Part B deductible was raised from $60 to $75 per year. The Part A deductible for those admitted to hospital was increased from $204 to $250 (it had been scheduled to rise to $228); in 1984 it will be $328. The coinsurance for extended care in hospitals and skilled nursing facilities was also raised.

Although appearing to be small, these increases

*In fiscal year (FY) 1982 the federal Medicaid expenditure limitation will be 3 percent below the FY 1981 formula requirement; in FY 1983 it will be 4 percent below and in FY 1984 it will be 4.5 percent below the present formula.

become significant when viewed in the context of the rapidly rising out-of-pocket costs that are already borne directly by the elderly, estimated to be in excess of $1,000 per capita in 1979, and the increasing rate of poverty among this population. The other major changes in Medicare and Medicaid are primarily in hospital reimbursement. These changes will reduce current levels of Medicare and Medicaid reimbursement for hospitals.

In attempting to contain Medicaid costs, at least six options are available to state governments: (1) reducing Medicaid eligibility, (2) reducing the scope of benefits, (3) holding reimbursement for hospitals, nursing homes or physicians at current levels as costs rise, (4) improving program management to reduce fraud and abuse, to reduce use, particularly of hospital services, and to eliminate inappropriate payments, (5) initiating delivery system reforms (for example, HMO's and vouchers) and (6) initiating program restructuring (such as long-term care block grants).

Our own and others' research indicates that several states have already begun to reduce the level of benefits and to restrict Medicaid eligibility. Two of the biggest items (and most likely targets) for Medicaid cost cutting are (1) reducing or eliminating eligibility for the "medically needy" and (2) reducing optional benefits, including intermediate care nursing home benefits. At the same time, hard-pressed cities and counties have been closing neighborhood clinics, hospital outpatient departments and other services, as well as restricting eligibility for city- or county-provided services.

If the medically needy Medicaid category now established by many states were limited in eligibility, many older persons would be removed from eligibility and would not be able to obtain needed services such as nursing homes, home care, and hospital and physician services or they would be forced to pay for these services out of pocket. Many of these elderly patients are in nursing homes at the time they become eligible for Medicaid. They have "spent down" their income and assets to a level that qualifies them for Medicaid. Reducing the income and asset requirements even further will shift the costs to the elderly and their families—many of them hard pressed or unable to meet the costs of such care.

Another approach to reducing Medicaid eligibility, which the states might initiate, would be to hold requirements to the level established for the previous years, while inflation continues to increase costs for food, housing and medical care. Spitz and Holahan and many others have advised that cutting back on Medicaid eligibility as a cost containment strategy may have unanticipated negative cost implications, such as shifting costs from one program to another or transferring costs from state to local government.[10,11] Although such a strategy may save the federal or state governments money, local governments may not be able to meet these demands. During recent years, the number of Medicaid eligibles has declined by almost 3 million, largely due to the failure of states to adjust Aid to Families With Dependent Children (AFDC) eligibility (thus Medicaid eligibility) to inflation.

Another likely method for states to control Medicaid costs would be to reduce or eliminate optional benefits (such as prescription drugs, intermediate care facilities, dentistry, physical therapy, prosthetics or optometry). There is little evidence that cutoff of certain optional benefits, such as prescription drugs, will reduce costs because some patients may have to be admitted to hospital to receive the necessary drug treatment. In such cases, the impact of eliminating some optional benefits may be to increase the overall program costs. Because the optional benefits of prescription drugs, dentistry and prosthetics constitute a minor portion of the overall budget and the cost increases of the Medicaid program, eliminating such programs may not reduce the Medicaid budget. And most important, the cutoff of optional benefits will affect those with the most chronic illnesses disproportionately, making them suffer the greatest hardships.[10,11]

Among the other alternatives, the most likely to have an immediate impact are reducing hospital, nursing home and physician reimbursement as well as further restricting Medicaid patients in their choice of private practitioner, community hospital and nursing home. These changes may be the ones most strongly resisted by the medical lobbies because the American Medical Association has indicated its preference for cuts in eligibility rather than cuts in reimbursement.[12]

Improved program management, including prior authorization for elective hospital admissions, utilization review, fraud and abuse control, audits and other management techniques have already been adopted in many state Medicaid

programs. It is unlikely, in our view, that these will produce sufficient short-term savings to compensate for the rising costs of medical care and the reductions in the federal share of expenditures. Delivery system reforms are also unlikely to be initiated soon enough to have a substantial impact on Medicaid expenditures in the next few years. They are much more likely to be encouraged for patients with private health insurance or Medicare coverage. Finally, program reforms, such as long-term care block grants, are likely to be considered but are unlikely to deal with the fiscal crisis in the short run.

The largest problem with the federal Medicaid spending limitation is that, in itself, it does nothing to address the source of rising medical care costs, particularly the increase in hospital costs. It merely shifts to the states the difficult and politically treacherous decisions about how to deal with those costs and the resultant public expenditures. Further, there has been little consideration of the possible cost shifts that the new Medicaid expenditure policy will generate—for Medicare or for programs funded by the state (such as SSI supplements and social services for the elderly).

There has been no published analysis of the possible consequences of the federal limitation on Medicaid for the Medicare program. Such an expenditure shift could occur, for example, if patients who are no longer eligible for nursing home coverage (because of Medicaid spending limits) are kept (at Medicare expense) for longer hospital stays than would occur if Medicaid nursing home coverage were available.

Decentralization and Block Grants

Budget cuts have also been made in the block grants, which represented the second major element in President Reagan's domestic social program proposals. In the 1970's this policy concept emerged under the banner of "new federalism," which converted several categorical programs to block grant type revenue-sharing programs (for example, Title XX of the Social Security Act). Designed to decentralize responsibility for domestic social programs to state and local governments through block grant type funding and to limit federal involvement in those programs, new federalism boosted the fiscal and political responsibility of state and local governments for multiple programs, including those affecting health care.[13] Both the block grants of the 1970's and those created in the Omnibus Budget Reconciliation Act of 1981 ease the constraints of categorical funding and of federal requirements, resulting in increased discretion for state government decision-making in multiple programs that affect the elderly, including such health programs as community mental health centers, home health services, emergency medical services and hypertension control.

An important consequence of the block grants is that the wide discretion that they provide the individual states fosters great inequities in the same program across the states. This, in turn, makes it impossible to assure uniform benefits for the same target population (for example, the aged) across jurisdictions or to maintain accountability with so many varying state approaches. Finally, because the most disadvantaged are heavily dependent on state-determined benefits, they are extremely vulnerable in this period of economic flux.

The net result of the large-scale shift to block grants in health and social services, combined with the across-the-board 25 percent reduction in FY 1982 federal expenditures for the block-granted programs, is increased pressure on state and local governments to underwrite program costs at the same time that many states, cities and counties are under great pressure to curb rising expenditures. The result is likely to be serious for elderly poor people in many communities.

Deregulation and Stimulation of Procompetition Market Forces

The third major policy initiative is deregulation and stimulation of procompetition market forces. These strategies are based on the assumption that market forces can produce an effective competitive medical care system and that the present system is not competitive except in ways that increase costs. Two distinct market structures have been proposed to meet the requirements of a competitive system: (1) the cost-sharing approach (large front-end deductibles and coinsurance) based on provider price competition over service price and (2) the health plan approach (such as health maintenance organizations and other plans that provide specified benefits for a population at a fixed premium through various practice arrangements). Although physicians, hospitals and others involved in medical care favor deregulation, there

is growing concern about and opposition to some of the procompetition proposals that are likely to be advocated by the Reagan administration. The writings of Enthoven and others give a clue to what these policy proposals will include.[14-16] The "competition strategy" described by Enthoven refers to the proposed application of the following four principles in health care financing: (1) multiple choice—each consumer would be offered the opportunity to enroll each year for the coming year in any of the qualified plans for health care offered in the area; (2) fixed dollar subsidy—each consumer would receive a fixed dollar subsidy (by his or her employer) toward the purchase of a health plan membership; (3) use of the same rules for all competitors would govern premium setting practices, minimum benefit packages, catastrophic expense protection and so on, and (4) organization of physicians into competing economic units, which could include group practices or other organizational arrangements, would be required.

Several procompetitive proposals have been introduced in the 97th Congress, including H.R. 850—National Health Reform Act of 1981 (Representative Gephardt); S. 433—Health Incentives Reform Act (Senator Durenberger), and S. 139—Comprehensive Health Care Reform Act (Senator Hatch). The Reagan administration has also indicated its intention to propose procompetitive legislation during this congress.

Although the bills differ in detail, there are several elements that characterize the procompetitive approach. These are (1) changes in tax treatment, for employers, employees or both, regarding employer contributions to health insurance plans; (2) establishment of incentives or requirements for employers to offer employees multiple choice of health insurance plans subject to certain limitations with respect to coverage of services and cost sharing, including catastrophic benefits and preventive care, and (3) establishment of Medicare and Medicaid voucher systems under which elderly, disabled, blind and AFDC-eligible persons would receive a fixed value voucher that could be used toward the purchase of a qualified health insurance plan.

One proposal being considered by the Reagan administration would provide Medicare-eligible persons with a voucher—initially worth perhaps $1,700 (average Medicare cost at present)—with which they could purchase private health insurance. The voucher plan may also include the provision that beneficiaries may opt to retain current Medicare coverage and that no voucher-eligible private plan can provide less coverage than Medicare itself. It is impossible to predict or provide an analysis of the likely consequences of this voucher proposal because few details of the administration's proposal have been made available. The voucher is, potentially, a mechanism for capping federal Medicare expenditures and shifting the financial risk to the individual patient. These elderly people might control expenditures by selecting a health insurance plan with the minimum required benefits.

The voucher may be a viable alternative for relatively healthly older people, particularly those who do not have chronic illnesses that require extensive medical and hospital care. However, for those with serious chronic illnesses and disability, particularly the poor, the picture is different. They may not be able to enroll individually in a plan that can meet the high costs that their care may entail. This is particularly true for the medically needy elderly who are in skilled nursing facilities or intermediate care facilities.

Much of the impetus for the procompetitive proposals comes from the success of health maintenance organizations in reducing costs for their controlled populations and for stimulating competition among providers in the fee-for-service sector. The picture is not that simple, as our colleague Harold Luft has pointed out.[17,18] It is clear that medical care costs for HMO enrollees are 10 percent to 40 percent lower than those in conventional plans. The factors that account for this reduced cost are less clear. It is evident that HMO's dramatically reduce hospital admissions, and for those in hospital, the length of stay and the use of services are slightly reduced. It is not clear whether part of the reduction in hospital use is due to (1) the particular consumers who select HMO's, (2) the group practice organization, (3) the lack of financial incentives for physicians to admit patients to hospital or (4) the more conservative practices of HMO physicians. A recent study comparing utilization patterns in a large multispecialty, primarily fee-for-service group practice and a prepaid group practice suggests that the group practice organization itself may be a critical factor in reducing hospital admissions.[19]

In analyzing the limited role that HMO's have

played in the care of the elderly, Harper, Butler and Newacheck[20] examined the factors that may influence HMO efforts to attract older patients, the factors that may stimulate older persons to consider joining HMO's, and the formidable obstacles to HMO enrollment of the elderly, particularly Medicare reimbursement of hospitals, the relationship of elderly patients to fee-for-service physicians, and people's reluctance to change to a new form of care. The authors concluded that without any change in Medicare policy, HMO growth in serving the elderly will take place slowly. This is an area that has been explored in only a few policy studies.

Two other approaches to cost containment strategies—also labeled procompetitive—have been proposed during the past decade. One of these approaches resembles Enthoven's strategy in that it attributes a large share of increases in health care cost to the spread of third-party coverage for the costs of care. This theory, which has been advanced by Feldstein,[21] Pauly and Seidman,[22] has been increasingly accepted as a major factor contributing to rising costs. The lack of incentives for provider and consumer restraint led Feldstein to propose that third-party coverage should be limited to catastrophic costs and that transactions between patients and physicians in day-to-day care should be subject to normal competitive market forces.

The other procompetition strategy, advocated by Havighurst and the Federal Trade Commission, is basically an antitrust strategy aimed at providers.[23] Advertising would be encouraged, and collusion among providers and other forms of illegal behavior would be prohibited. Again, the stress is on the market and on permitting it to function in a traditional fashion.

In view of the procompetitive proposals—particularly those using vouchers and changes in tax policy—that are likely to emerge as public policy in the coming months, the best strategy would appear to be one of well-designed experiments coupled with careful monitoring of the medical care market to analyze the effects of alternative approaches on access, quality and cost, and reduction of disincentives to competition (such as tax subsidies to employers who purchase expensive health insurance plans for employees or current Medicare reimbursement policies); most informed observers believe that increased regulation will also be needed to stimulate competition. It is paradoxical that to stimulate competition, which may actually control cost increases, regulation must be increased.

In view of the recent federal policy shifts affecting health care for the elderly—particularly expenditure reductions, block grants and deregulation-procompetition proposals—we believe several steps are necessary. First, we believe it is necessary to initiate federal and state policy monitoring and policy analysis, as well as health services evaluation at the local level to assess the impact of the policy shifts on state and local governments, on providers, on the elderly and on other groups dependent on public programs and institutions for needed services. Because of the importance of independent sector (nonprofit) institutions in providing services for the elderly, we believe it is particularly important to assess the impact of federal and state policy changes on these institutions and on the elderly whom they serve.

These are indeed times of change and challenge for physicians and health care institutions and for the elderly they serve. To meet the formidable challenges ahead, physicians must be better informed about the impact of public policies on health care for the elderly; further, they must examine more critically what can be done within medicine to meet the health care needs of those with chronic illnesses and disability, particularly elderly patients. We believe, as do many others, that the resources devoted to health care are ample to meet the needs, but they will not be if we continue down the path that medicine has followed for the past 30 years.

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